Torch Healthcare Services Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: Torch Healthcare Services Ltd is a small domiciliary care agency providing personal care to people in their own homes. Not everyone using the service receives the regulated activity; CQC only inspects the service being received by people provided with 'personal care', help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

People's experience of using this service:
People were not protected from harm because systems were not in place to keep them safe. People's medicines were not managed safely as the service did not have safe systems in place. People were not being supported by staff who had gone through thorough recruitment checks.

People were not provided with effective care as staff had not been trained or had the support to carry out their roles. Despite the concerns people told us they thought their care workers were kind and caring.

People's care plans did not provide the information required for staff to know the support needed. People had not always been able to be involved in the care planning process or have a review of their care.

The quality monitoring systems in place were inadequate and had not identified areas for improvement which meant the registered manager was not always aware of concerns. Action plans sent to us following our last inspection stated the action required would be completed by October 2018. The action had not been carried out.

The registered manager had not notified us of all incidents that required a notification to us by law.

Rating at last inspection: At our last comprehensive inspection which was published in August 2018 the service was rated as Requires Improvement. Following our inspection we asked the provider to complete an action plan to show what they would do by when to make the required improvements.

Why we inspected: This is a planned inspection based on the previous inspection rating.

Enforcement: We have found five repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, we have found one breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in 'special measures' will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of Inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as Inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to the more serious concerns found during inspection is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Torch Healthcare Services Ltd

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: Torch Healthcare Services Ltd is a small domiciliary care agency providing care to people in their own homes. At the time of our inspection the service was supporting 18 people.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: We gave the service 48 hours' notice of the inspection site visits because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be available.

Inspection site visit activity started on 13 February 2019 and ended on 14 February 2019. We visited the office location on to see the manager and to review care records and policies and procedures.

What we did:
Before our inspection we looked at information we held about the service. This included notifications received from the provider which they are required to send us by law. Before the inspection the provider

completed a Provider Information Return. This is a form that asked the provider to give key information about the service, what the service does well and improvements they plan to make.

During our visit we spoke with nine people and one relative. We spoke with the registered manager and four members of staff. We looked at seven care plans, medicines administration records, audits, accident records and other records relating to the management of the service.

Following our site visit we contacted two social care professionals for their feedback about the service and how it is run. We also contacted the provider for further information.

Inadequate

Is the service safe?

Our findings

At our last inspection in June 2018 we found the service was not safe. We rated the key question Safe as Inadequate because we found breaches of Regulation 12, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we have not seen sufficient improvement to address the breaches of Regulation 12 and 19.

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Using medicines safely

- At the last inspection we had concerns about how the service managed medicines. At this inspection whilst the service had made some improvements, there were still areas of concern.
- People's medicines administration records (MAR) did not always contain the detail needed for staff to be able to know what the person was prescribed. Where people were prescribed 'as required' PRN medicines there was no protocols in place to help guide staff to know when to administer this type of medicine. The MAR had no details about how to administer this type of medicine or how much to give. This was a particular concern where people were prescribed oral morphine or paracetamol. One person who was prescribed morphine had no dose or route recorded on their MAR. We asked staff how much they would administer this person. They told us the person had a dose of 2.5 mls but they were not able to tell us how many doses the person could have per day. This meant people were at risk of overdose. Where people were prescribed paracetamol PRN there was no guidance for staff to know how many tablets to give and what the maximum dose would be in 24 hours. This meant that people were at risk of being overdosed.
- At our last inspection we found that handwritten entries on the MAR had not been dated or signed. At this inspection this had not improved. We found many entries where staff had amended the MAR but had not dated the entry or signed the MAR. This increases the risk of transcribing errors. Royal Pharmaceutical Society guidelines state that if care workers use hand-written MAR, there must be a system to check the details are correct.
- At our last inspection we found that staff administering medicines had not received the required training to administer medicines or had their competence assessed. At this inspection we saw the provider had ensured all staff completed a medicines awareness e learning module. However, the provider had not assessed any member of staff's practice to administer medicines. This meant they could not be sure staff were competent.
- At our last inspection we found unexplained gaps on people's MAR which meant that the provider could not be sure people had received their medicines. At this inspection we found there were still unexplained gaps on the MAR. The gaps had not been identified by staff so that the provider could check if the person had received their medicines.
- We found a number of incidents involving medicines management that the registered manager was not aware of. This meant they had not taken the appropriate action to investigate the incidents. People were not always receiving their medicines as prescribed. For example, we saw a handwritten note on one person's MAR that the medicines were still in the person's 'dosette box' but they had been signed on the MAR as

being administered. This had not been investigated. We saw two entries written on a person's MAR which stated the care worker had not turned up for the visit so medicines had not been administered. This had not been investigated. We raised this with the registered manager to address without delay.
•□We found an incident form which recorded that a person's medicines had gone missing from their home. The registered manager was investigating this incident at the time of our inspection. They had not informed the local safeguarding team of this potential abuse. We asked them to do this without delay.

Learning lessons when things go wrong
•□The provider was not learning when things went wrong as not all incidents had been reported and investigated. Whilst the service had introduced a new incident form which had improved incident recording, not all incidents were recorded. This meant management had not been able to investigate and share any learning to prevent re-occurrence.
•□Whilst the management team had meetings, there were not meetings held for care workers. This meant the opportunity to discuss and learn from incidents was not readily available to all staff.

Systems and processes to safeguard people from the risk of abuse
•□Systems were not in place to keep people safe and not all staff had received training on safeguarding. We found incidents recorded on MAR that should have been reported to the registered manager so that investigations could take place.
•□People's calls were being missed or the care worker was significantly late. The system put in place to monitor this was not robust and had not identified all missed calls. This meant people were not safe and at risk as they were not able to have their medicines or help with their personal care.
•□Staff did not know how to report all incidents of concern around safeguarding. One member of staff we spoke with told us of an incident which they reported to a family member not the registered manager. This meant the service had not shared this information with the local safeguarding team so that appropriate action could be taken. We raised this concern with the registered manager and asked them to look into this incident.

These areas are a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□Despite the shortfalls we have identified people told us they felt safe being supported by this service. Comments included, "They [staff] take me out, I feel very safe", "They [staff] administer my medicines well" and "The staff check everything, turn off the lights and close the doors, I feel very safe."

Staffing and recruitment
•□At the last inspection recruitment and staffing was not safe. At this inspection whilst staffing levels had improved, recruitment remained unsafe.
•□The provider had not completed the required pre-employment recruitment checks. Full employment histories had not been obtained, references had not been secured and health checks had not been completed. This meant the provider could not be sure they had fit and proper persons employed.
•□One recruitment file had correspondence from the provider trying to obtain references for a member of staff after they had commenced working for them. The provider obtained one reference for this member of staff from an employer not listed on the application form. We asked the registered manager about this during our inspection, they did not know when the member of staff had worked for this employer, in what role or for how long.
•□For two members of staff criminal convictions were noted on their Disclosure and Barring (DBS) check. The provider had not carried out thorough recruitment checks to make sure these members of staff were of

good character. One of these members of staff had no references on their file. The provider had not checked their employment history in full or obtained any other means of checking their character. The other member of staff had one reference on their file which was from an employer not on their application form. We were unable to verify if the member of staff had worked for them, in what role and for how long. The registered manager was also not able to tell us this information.

•□In addition, there was no risk assessment in place for either of these members of staff to assess the risk of them working alone with people. The provider had written a statement on one of the staff files to state they were aware of the DBS information and considered the member of staff safe. They stated their decision was based on their recruitment checks which they had not carried out in full. We asked for an urgent risk assessment to be completed for one of the members of staff.

These areas are a repeated breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□There were sufficient numbers of staff employed. The registered manager told us they had not increased the numbers of people receiving a service. This was because the local authority had prevented them from starting new services with people. This was due to the concerns found at the last inspection.

•□Staff we spoke with told us that they worked less hours since our last inspection. They also said there were "compulsory days off" in place now and there was no expectation staff would work every day.

Preventing and controlling infection

•□Not all staff had been trained on infection prevention and control. Staff were given personal protective equipment to use such as gloves and aprons. One person said, "All staff wear gloves and aprons for personal care."

Assessing risk, safety monitoring and management

•□People's individual risks had been identified and they had risk assessments in place which were reviewed regularly. Risk assessments were in place for areas such as falls and moving and handling. This had been a concern at our last inspection.

•□Risk assessments had guidance for staff to follow to keep people safe in those areas.

•□The service had bought staff mobile phones so they could make sure they had the means to call for assistance if they needed. There was a new electronic rota planner in place which identified which members of staff were where. This helped the management monitor the staff whereabouts.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in June 2018 we found the service was not effective. We rated the key question Effective as Requires Improvement because we found a breach of Regulation18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we have not seen the improvement required to meet the breach.

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI:The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience

- Following our last inspection, the service had introduced a new system for staff training. There were e learning modules available for staff to complete in identified areas. For training the provider considered as mandatory we found that there were significant gaps. There were 13 staff employed at Torch Healthcare Services. We found four staff required first aid training, four staff required food hygiene training, seven staff required safeguarding training and infection prevention and control training. Staff had also not had their competence to administer medicines checked to make sure they were safe. This is reported in more detail in the key question Safe.
- No staff had completed any training on equality, diversity and inclusion. This e learning module had not been allocated to any staff to complete. Within the complaints records we saw a complaint made by staff about a person. The complaint demonstrated that there might be a lack of understanding of people's needs. We discussed this with the registered manager during our inspection who told us they would allocate it as a required training module.
- Not all staff had the opportunity to have a supervision. Two members of staff who started work in September and October 2018 had only been provided with one supervision. They told us they did not see their supervisor often but could chat to them on the phone. Newer members of staff may benefit from structured supervision whilst they are learning about their roles. Another member of staff had one supervision since our last inspection in June 2018. There had also been no staff meetings so that staff could raise issues, or gain support from their peers.

This is a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed by the registered manager in a pre-service assessment. We found the assessments did not always record all of people's needs. This was a concern with regard to people's healthcare needs, for example, if a person required support with a catheter. A catheter is usually used when people have difficulty urinating naturally.

Supporting people to eat and drink enough to maintain a balanced diet

- Some people required help and support to prepare a light meal. This varied from help to prepare a light snack and drinks to preparation of a microwave meal.

Staff working with other agencies to provide consistent, effective, timely care

- The service worked in partnership with various agencies to support some people with complex needs. They were working alongside other care providers, community nurses and occupational therapists to make sure people's needs were met. One person told us, "The occupational therapist from hospital was involved in the care planning meeting, as well as the care company."

Supporting people to live healthier lives, access healthcare services and support

- People were able to access healthcare professionals where needed as staff supported them. One person told us, "They [staff] supported me to call the district nurse; and she came."

Ensuring consent to care and treatment in line with law and guidance

- The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
- We checked whether the service was working within the principles of the MCA and found they were. The service was not supporting any people who could not consent to their care. Staff we spoke with told us they always asked for people's consent before providing care. Staff had received training on MCA.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI:People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence
•People's pin codes to access their properties were not stored safely. Whilst records were stored securely in the office, there were not safe systems in place to store access codes. We discussed this with the registered manager and asked them to make other arrangements without delay.
•Staff we spoke with gave us examples of how they promoted dignity. Examples included, not leaving people exposed when supporting them with personal care, always making sure a towel is placed over them, knocking on doors before going into rooms and leaving people if they are safe in bathrooms for privacy until they are ready for support.

Supporting people to express their views and be involved in making decisions about their care
•The registered manager told us they were starting to ask people their view of the service and check if the care they received met their needs. Not everyone had been asked their views or had the opportunity to be involved in decisions about their care.
• People we spoke with told us they had not received a review of their care. One person said, "It has been more than a year since my review." One person's care plan had been created in May 2018 but had not yet been reviewed. We asked the registered manager about this person's needs and found they had changed since the care plan was written. The registered manager told us they would review this care plan promptly.

Ensuring people are well treated and supported; equality and diversity
•People and relatives told us they liked their care workers and were happy with the care they received. Comments included, "They [staff] are good and patient. They are behind her coaxing her along, worth their weight in gold" and "They [staff] are bouncy and pleasant whatever the task. There is good humour."
•People told us they were being supported by staff who were kind and caring. Comments included, "They [staff] are absolutely wonderful", "They [staff] chat about my family, which is nice. They are kind hearted" and "Their [staff] whole attitude is kind. They are very gentle, they take care of my skin."
•Staff told us despite the shortfalls they enjoyed their jobs. One member of staff said, "I have a good relationship with clients, they have a good level of care. I am supporting some lovely people."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in June 2018 we found the service was not responsive. We rated the key question Responsive as Requires Improvement because we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw the service had not made the required improvement.

Responsive – this means we looked for evidence that the service met people's needs

RI:People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People's needs were assessed and recorded in a personalised care plan. Whilst the care plan contained detail on needs such as moving and handling, personal care and communication there was a lack of detail on health care needs.
- One person had a significant pressure ulcer which required treatment from community nurses. Whilst the community nurses were visiting regularly to treat the wound the care workers were part of the treatment plan. Their role was to make sure the person was offered and given pain relief prior to the community nurses visiting. They also had to make sure the person wore a special pressure relieving gel boot. There were no details in the person's care plan about pain management. There was no information on what the wound was or what treatment it required. Guidance for staff about the gel boot had been written by the nurses and taped to the person's file. This guidance was becoming worn and the paper was tearing in places. We raised this with the registered manager as we were concerned it could become lost or unreadable.
- One person's care plan did not have any detail recorded for staff to know what help the person needed with their medicines. This person was receiving four visits per day which were all to help in part with their medicines. We were not clear what support they required.
- Another person had a catheter in place, which is usually used when people have difficulty urinating naturally. The care plan stated the catheter bag required 'changing weekly'. There was no other guidance about who was changing the catheter bag or how to do this. There was also no information about how staff were to monitor the person's urine, what may indicate a concern and what to do about concerns.
- One person's daily notes demonstrated that staff were applying various topical creams. Whilst these actions were recorded in the notes there was no other guidance to guide staff as to what cream to apply and where on the person's body. We saw that three different creams were being used with no record of where on the body they had been applied.

This is a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- Complaints were logged and investigated by the service manager. There were records of the investigations and the outcomes. Where needed letters of apology were sent.

End of life care and support

- There was no end of life care and support being provided at the time of our inspection. Some people had made decisions not to be resuscitated which was recorded in their care plans.

Inadequate

Is the service well-led?

Our findings

At our last inspection in June 2018 we found the service was not always well-led. We rated the key question Well-led as Requires Improvement because we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found four additional breaches of the Regulations in other key questions. We served the provider two warning notices. At this inspection we have not seen the required improvement. The service is now rated as Inadequate in Well-led. In addition, there is a repeated breach of Regulation 17 which means the service is now rated as Inadequate for Well-led.

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate:There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

•At our last inspection we found the service had no quality monitoring systems in place. At this inspection we saw the provider had introduced some audits. There were audits in place to monitor medicines administration records (MAR) and daily recording notes. The provider had also commenced 'spot checks' on staff whilst they were carrying out their visits. These audits were not effective as they did not identify all the concerns we have found. Where concerns were identified there were no action plans in place to identify how the service was going to improve, and by when. There was also no indication of who was responsible for completing any improvements.
•MAR audits were being completed monthly. We found two audits completed in December 2018 for two people that did not identify any issues. The audits recorded that the MAR were 'good'. Handwritten on both MAR were concerns identified by a relative and a member of staff. One recorded that staff had not turned up for a visit so a person had not had their medicines. The other recorded that medicines were in the 'dosette box' but had been signed as given on the person's MAR. The MAR audits failed to identify these incidents in order that an investigation could be carried out. We asked the registered manager to investigate these incidents.
•Daily recording notes were being audited monthly. These audits had identified practice that required improvement. One person's daily records had been written on documentation that was not correct. The audit of the person's notes had identified this on the 11 December 2018. Staff continued to use incorrect documentation until the 31 December 2018. Another person's daily notes audit identified that there were no daily notes for a period of six days. The audit had 'why?' written on it but there was no action taken to follow this omission up.
•Daily recording audits were not monitoring the times of calls despite the times being clearly recorded by staff. We saw for one person their daily visit was consistently between 15 minutes and 20 minutes in duration. Their care plan recorded that they were to have a 30-minute visit. We raised this with the registered manager and asked them to look into this without delay.

•□The registered manager showed us they were monitoring missed calls to try and reduce the amount of times people did not receive a call. We found their monitoring did not include any of the missed calls we found during this inspection. We raised this with the registered manager who agreed it needed to be more robust.
•□Following our last inspection in June 2018, the provider sent us action plans to inform us how they were going to make the improvement required and by when. At this inspection we found that the action the provider told us they were going to take by October 2018 had not taken place.
•□At our last inspection we found recruitment checks were not safe, medicines were not managed safely and staff had not been trained effectively. Following that inspection, the provider sent us an action plan detailing the action they would take to address the breaches of Regulations. They told us they would take action on recruitment checks such as, 'Staff files will also regularly be audited and brought up to date by both management and the HR Department. This will ensure that all information is up to date and accurate'. To address the shortfalls in staff training and support they told us, 'We will ensure that staff training, and induction is comprehensive by having regular supervision records that discuss the needs of the staff and clients as part of the agenda'. These actions and others within the action plan had not been carried out.
•□Following our site visit we asked the provider to send us two pieces of information. Within the first piece of information we found inaccuracies, we asked the provider to address this without delay. The second piece of information sent to us was not what we asked for. Again, we had to ask the provider to review the information shared and make changes.

The failure to operate effective systems to assess, monitor and improve the service was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□At our last inspection we found incidents that had not been notified to us. The registered manager completed notifications during our inspection and sent them to us. At this inspection, we found there were two allegations of abuse that had not been notified to us. We found an incident which was logged on the 27 January 2019 which had not been notified to us or the local authority safeguarding team. This meant the provider had not acted to keep people safe or complied with the requirements of their registration. The registered manager completed the notifications following our inspection, however it was clear they were unsure about what incidents required reporting to us.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
•□The care provided was not always person-centred and of a high quality. This has been demonstrated in the earlier parts of this report.
•□There was not an open and transparent culture at the service. Lessons were not being learned from incidents as they were not being shared with the team. Letters of apology had been sent to people and their families where there was a missed call, however there was no evidence to demonstrate any learning to prevent reoccurrence.
•□Leadership at the service was visible and approachable however, we are concerned about the lack of skills to make the improvement needed. The registered manager told us they are supported by a service manager. At our last inspection the service manager told us they were going to register to become manager of this service. They showed us the DBS check we carry out on prospective registered managers. We have found that the service manager had not applied to become registered for Torch Healthcare Services but for another service in a different county. When we asked the registered manager about this they were not sure why the service manager had registered for this other service. They told us they were working four days a

week at their service.

Continuous learning and improving care

• Systems were not in place to drive improvement. The registered manager did not have leadership oversight of the service, what needed to improve or how to make the improvement required. Checks that had been put in place to make improvement were identifying the same issues repeatedly. For example, daily notes were being checked monthly, the member of staff checking the notes identified staff were writing in blue pen. This was repeatedly identified as an issue as the provider required staff to record their notes in black pen. We asked the registered manager why the staff were not writing in black pen despite being told to. They were not sure, they thought it was because the staff did not have black pens. The registered manager did not demonstrate the skills required to drive improvement.

• Staff we spoke with recognised that the service needed to improve. They told us they thought over the past six months the service had taken action to improve. One member of staff said, "Things have changed for the better, [provider] have learned a lot. They are learning all the time about the rules and regulations."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• The provider had asked some people their views on the service provided but not all the people using the service. Reviews of people's care had not routinely been carried out with the person. This meant that people did not always have the opportunity to contribute to their care plan.

• Staff we spoke with enjoyed working for the provider despite the shortfalls. Comments included, "I love working for Torch, I feel valued, the [registered] manager always says thank you" and "Torch has improved a lot, their [management] hearts are in the right place."

Working in partnership with others

• The registered manager told us they wanted to improve the service and provide good quality care. They had recently commenced working with the local authority quality team to try to put into place systems to improve the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not always notified us of safeguarding incidents. 18 (1) (2) (e)

The enforcement action we took:

Fixed Penalty Notice

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plans did not contain sufficient detail to guide staff to provide the right care and support. 9 (1) (a) (b) (2) (3) (a) (b) (c) (d)

The enforcement action we took:

We have served a Notice of Decision to cancel this providers registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. Incidents were not always identified or reported so that action could be taken to keep people safe. Incidents of safeguarding had not always been reported to the local safeguarding team. 12 (1) (2) (a) (b) (c) (g)

The enforcement action we took:

We have served a Notice of Decision to cancel the providers registration.

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring systems put into place by the provider did not always identify the improvement required for the service to provide good quality care. Where improvement had been identified the provider had not carried out the action needed to keep people safe. Following our last inspection the provider submitted action plans to inform us of the action they were taking and told us by when it would be completed. This action had not been carried out. 17 (1) (2) (a) (b) (c) (f)

The enforcement action we took:

We have served a Notice of Decision to cancel the providers registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not carried out the required recruitment checks on staff to make sure they were of good character and safe to work with people. 19 (1) (a) (b) (c) (2) (a) (3) (a) (b)

The enforcement action we took:

We have served a Notice of Decision to cancel the providers registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not had appropriate support, supervision or training to enable them to carry out their duties. 18 (1) (2) (a)

The enforcement action we took:

We have served a Notice of Decision to cancel the providers registration.